14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

DATE OF REVIEW: **12/29/2014**

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Caudal Epidural Steroid Injection with IV sedation.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

D.O. Board Certified in Anesthesiology and Pain Management.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a male who was injured at work. Patient is reporting left hip weakness, back pain, bilateral leg pain (worse on the left than the right). Patient does have a history of previous injury where he slipped and fell and was treated by a chiropractor; no previous injections were performed. Patient was treated previously with six sessions of physical therapy, as well as an x-ray and an MRI of the lumbar spine were performed. X-ray showed osteophytes at L2-3, L3-4, and L4-5. No fractures noted on x-ray. MRI showed disc herniation on the right at L2-3, and foraminal stenosis at L3-4 and L4-5.
Patient is presently taking cyclobenzaprine 5mg TID, Norco 10/325 bid, Axiron 30 mg, Ibuprofen, and Simvastin. Physical exam was significant for iliopsoas weakness 4-5 on the left. No other physical findings were noted on physical exam.

ANALYSIS FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION AND EXPLANATION OF THE DECISION. INCLUDE CLINICAL BASIS,

Per ODG references the requested "Lumbar Caudal Epidural Steroid Injection with IV sedation" is not medically necessary.
The patient is not exhibiting any radicular symptoms, and no radicular component was reported on the physical exam. The only positive finding on physical exam was 4-5 weakness on the left iliopsoas area. No EMG results were provided to support any radicular component either.

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☐ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES